Community Services and Support (CSS)
SECOND DRAFT of
Program and Expenditure Plan
Requirements

Mental Health Services Act
Conference Call
Monday, May 23, 2005
3:00 PM – 4:00 PM
Toll Free Call In Number: 1-877-366-0714
Verbal Password: MHSA
TTY# is 1-800-735-2929

Second Draft of CSS Requirements Conference Call Agenda

- 3:00 Welcome and Purpose of Call--Bobbie Wunsch
- 3:02 Review Agenda and Conference Call Process—Bobbie Wunsch
- 3:05 Review of Changes (slides 1-12)—DMH Staff
- 3:15 Questions and Answers—Bobbie Wunsch
- 3:30 Review of Changes (slides 13-29)—DMH Staff
- 3:45 Questions and Answers—Bobbie Wunsch
- 3:58 Next Steps—Bobbie Wunsch
- 4:00 Adjourn

Input is being sought to:

- Eliminate any errors/omissions
- Determine where clarification is needed
- Obtain suggestions for streamlining
- Continue the discussion on the issue of MHSA funding of involuntary services

Overview of Changes

- Three DRAFT Documents
  - Three Year Program and Expenditure Plan Requirements
  - Technical Assistance Documents
    - Including Revised Considerations for Embedding Cultural Competency
  - Readers Guide

Program and Expenditure Plan Requirements—Overview

- Purpose of Document Remains the Same—it is intended to:
  - Clearly specify requirements and priorities
  - Assure consistency with MHSA
  - Move toward system transformation
  - Focus efforts and produce meaningful and measurable outcomes statewide
  - Support local priorities within the above parameters

Program and Expenditure Plan Requirements—Overview of Changes

- Incorporated stakeholder feedback
- Clarified and simplified plan requirements
- Increased emphasis on client and family direction, peer support efforts and client and family run programs
- More strongly embedded cultural competence
- Included small county exceptions

Overview of Revisions—continued

- Used more appropriate language for children and youth and more examples from all age groups and special needs populations
- Revised policy regarding use of MHSA funds for involuntary services
  - Services/programs funded with MHSA funds must be voluntary in nature
  - Individuals regardless of legal status may access these expanded services

Individual Outcomes

- The revised document also emphasizes individual issues and the importance of measuring outcomes achieved by specific individuals and families, including but not limited to:
  - Hope
  - Personal empowerment
  - Respect
  - Social connections
  - Independent living for adults and safe living with families for children/youth
  - Self-responsibility
  - Self-determination
  - Self-esteem for clients and families

Expanded Language on Statewide Outcomes

- Meaningful use of time and capabilities, including things such as employment, vocational training, education, and social and community activities
- Safe and adequate housing, including safe living environments with family for children and youth; reduction in homelessness
- A network of supportive relationships

Expanded Language on Statewide Outcomes

- Timely access to needed help, including times of crisis
- Reduction in incarceration in jails and juvenile halls
- Reduction in involuntary services including reduction in institutionalization and out of home placements

Five Fundamental Concepts for Plans

- Revised and refined these concepts based on stakeholder language and refer to them throughout the plan requirements
  - Community collaboration
  - Cultural competence
  - Client/family driven mental health system for older adults, adults and transition age youth and family-driven system of care for children and youth
  - Wellness focus, which includes the concepts of recovery and resilience
  - Integrated service experiences for clients and their families throughout their interactions with the mental health system

Three Types of Funding (p.8)

Overall focus on eliminating ethnic disparities

1. Full Service Partnerships

   Partnerships between individual/family and mental health system that are culturally competent, include individualized client/family driven services and offer integrated service experiences. The goal is to provide all needed cost efficient and effective services and supports

2. System development

   Funding to improve/transform structures, services and support for all clients and families

3. Outreach and engagement

   Funding for special activities needed to reach unserved and significantly underserved populations

Structure of Plan Requirements

- Part I: County/Community Public Planning Process
  - Section I: Brief description of actual planning process
    - Counties with conditions in their approval must provide significant additional detail
    - Counties may resubmit parts of their plan to eliminate the conditions
  - Section II: Description of local review and public hearing
  - This part must be approved before the state will review Part II for funding

Part II—Program and Expenditure Plan Requirements

- Document follows logic model that links:
  - Community issues resulting from untreated mental illness and a lack of services and supports
  - Mental health needs within the community
  - The identification of specific populations to be fully served based upon the issues and needs identified
  - The strategies and activities to be implemented and
  - The desired outcomes to be achieved

Section I: Identifying Community Issues

- Stakeholders are asked to examine the issues identified in the MHSA and others in the context of their communities and identify which of these community issues and concerns they will focus on in their initial three-year plan
  - Issues should be identified and discussed by age groups
- The selection of community issues to be addressed should inform a county's choices about which populations or groups of individuals will be identified for Full Service Partnership funding in this first three-year plan

Section II: Analyzing Mental Health Needs in the Community

- Counties must provide an assessment of the mental health needs of county residents in each of the four age groups, looking at three categories – unserved, underserved/inappropriately served and fully served
  - Definitions and examples are provided
- Revisions make explicit that although counties may elect to provide new or expanded services to underserved individuals, DMH expects counties to emphasize unserved individuals and their families in the priority populations for MHSA funding

Section II: Analyzing Mental Health Needs in the Community

- To aid in their unmet needs analyses, counties are instructed to update their population assessments in their FY 2003/04 Cultural Competence Plans to include their total population, not just Medi-Cal, and to provide this as part of their application
- Counties will not be required to provide detailed analyses and specific numbers of unserved, but must provide some general descriptions and estimates of this population

Section III: Identifying Initial Populations for Full Service Partnerships

- Goal is to have counties begin to move toward entering into Full Service Partnerships with all clients
- Counties must specify the numbers of individuals they will serve in this manner, by age group, within the first three years of MHSA funding, with priority given to unserved populations
- Overall, counties must request the majority of their funding for Full Service Partnerships over the three-year period.
  - Does not apply to small counties until third year

Section III: Identifying Initial Populations for Full Service Partnerships

- Each individual/family to be fully served must be offered the opportunity to participate in a Full Service Partnership and to develop an individualized services and supports plan

Section III: Identifying Initial Populations for Full Service Partnerships

- Full Service Partnership includes:
  - Individualized service plan that is person/child-centered, with individuals and their families given sufficient information to allow them to make informed choices
  - Provision of all necessary and desired appropriate services and supports to assist in achieving the goals identified in the client's plan
  - Identification of a single point of responsibility – PSC or case manager with a low enough caseload to respond as needed and give the client/family considerable personal attention

Section III: Identifying Initial Populations for Full Service Partnerships

- Full Service Partnership includes:
  - 24/7 response capability by PSC/case manager or team members known to client/family
    - Small counties may also use community partners to meet this criteria
  - Linkage to or provision of all needed services with the capability of increasing or decreasing service intensity as needed

Section III: Identifying Initial Populations for Full Service Partnerships

- DMH will develop standardized outcome/ performance measurement requirements and counties will be required to submit service, assessment and indicator/outcome information for each person/family who is fully served with MHSA Funds

- Responses have been simplified: Detailed matrix of numbers, etc. have been moved to workplan

Section IV: Identifying Strategies

- Strategies are to be used to build infrastructure and capacity to serve a diverse population of clients and their families

- Counties are encouraged to pursue collaborative funding and leverage other funding sources in addition to MHSA funding wherever possible, but plans should not be driven by the goal of maximizing Medi-Cal

Section IV: Identifying Strategies

- CSOC and Wraparound core values and principles have been incorporated in strategies for children, youth and families
- Increased emphasis on peer support, self-help and client/youth/family-run programs in all age groups
- All counties must develop and/or expand peer support and family education services within their three-year plan
- Additional strategies have been added for small counties and for outreach and engagement efforts

Section IV: Identifying Strategies

- Distinctions between structural, service and support strategies have been eliminated and types of strategies have been expanded
- Clarifies that strategies may be funded by any of the three types of funding as appropriate
- Requires the development or expansion of peer support and family education support services.

Section V: Assessing Capacity

- The chart on current staffing capacity has been eliminated and responses have been simplified

- Counties are asked to identify possible barriers they may have in implementing their plans and how they will address and overcome these challenges

Section VI – Developing Workplans with Timeframes

- Workplans have been simplified

- Counties must submit separate workplans for each of the three types of funding and for each age group to receive services within each type of funding
- Timelines are required with critical implementation dates which will be used in quarterly progress reporting

Section VII: Developing the Budget

- Budget will be tied to workplans
- Format has been simplified and a staffing detail worksheet has been added
- A separate budget is provided for County administrative costs for managing programs/services under the MHSA
- A program management line item for contract providers and other county agencies has been added

Section VII: Developing the Budget

- Where a contract provider is known, a detailed line item budget is required
- If the contract provider is not yet known, only the total estimated contract amount is required
- Individual line items will be used by DMH to evaluate the plan. Counties have flexibility to move funds between line items but cannot exceed the total cost without a plan amendment